106TH CONGRESS
1ST SESSION

H. R. 216

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and preserve against preemption certain State causes of action.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 6, 1999

Mr. NORWOOD introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and preserve against preemption certain State causes of action.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Access to Quality Care Act of 1999".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—ACCESS TO QUALITY CARE

Subtitle A—Promoting Quality Care by Ensuring Access to Health Care Professionals

SEC. 101. CONSUMER CHOICE OPTION.

(a) IN GENERAL.—If a health insurance issuer offers to enrollees health insurance coverage which provides for coverage of services only if such services are furnished through health professionals and providers who are members of a network of health professionals and providers who have entered into a contract with the issuer to provide such services, the issuer shall also offer to such enrollees (at the time of enrollment) the option of health insurance coverage which provides for coverage of such services which are not furnished through health professionals and providers who are members of such a network unless enrollees are offered such non-network coverage through another health insurance issuer.

(b) FAIR PREMIUMS.—The amount of any additional premium required for the additional cost of the option described in subsection (a) may not exceed an amount that

is fair and reasonable, as established by the applicable State authority, in consultation with the National Association of Insurance Commissioners, based on the nature of the additional coverage provided.

(c) ADDITIONAL COSTS.—The amount of any additional premium charged by the health insurance issuer for the additional cost of the creation and maintenance of the option described in subsection (a) shall be borne by the enrollee unless it is paid by the health plan sponsor through agreement with the health insurance issuer.

(d) OPEN SEASON.—An enrollee may only change to the offering provided under this section only during a time period determined by the health insurance issuer. Such time period shall occur at least annually.

(e) COST SHARING.—Under the option described in subsection (a), the health insurance coverage shall provide for reimbursement rates for covered services offered by health professionals and providers who are not participating health professionals or providers that are not less than the reimbursement rates for covered services offered by participating health professionals and providers. Nothing in this section shall be construed as protecting an enrollee against balance billing by a health professional or provider that is not a participating health professional or provider.

SEC. 102. CHOICE OF HEALTH PROFESSIONALS AND PROVIDERS.

(a) CHOICE OF PERSONAL HEALTH PROFESSIONAL.—A group health plan, and a health insurance issuer that offers health insurance coverage, shall permit each participant, beneficiary, and enrollee to—

(1) select a personal health professional from among the participating health professionals of the issuer, and

(2) change such selection—

(A) in the event of a disciplinary complaint against the provider; or

(B) at least once every 4 months.

SEC. 103. ACCESS TO CARE.

(a) IN GENERAL.—A group health plan, and a health insurance issuer that offers health insurance coverage shall establish and maintain adequate arrangements, as defined by the applicable State authority, with a sufficient number, mix, and distribution of health professionals and providers to assure that covered items and services are available and accessible to each participant, beneficiary, and enrollee under health insurance coverage—

(1) in the service area of the issuer;

(2) in a variety of sites of service;

(3) with reasonable promptness (including reasonable hours of operation and after hours services);

(4) with reasonable proximity to the residences or workplaces of enrollees; and

(5) in a manner that—

(A) takes into account the diverse needs of enrollees, and

(B) reasonably assures continuity of care.

A group health plan, and a health insurance issuer that offers health insurance coverage that serves a rural or medically underserved area shall be treated as meeting the requirement of this subsection if the plan or issuer has arrangements with a sufficient number, mix, and distribution of health professionals and providers having a history of serving such areas. The use of telemedicine and other innovative means to provide covered items and services by a group health plan, and a health insurance issuer that offers health insurance coverage that serves a rural or medically under served area shall also be considered in determining whether the requirement of this subsection is met.

(b) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as requiring a group health plan, and a health insurance issuer that offers health insurance coverage—

(1) to have arrangements that conflict with its responsibilities to establish measures designed to maintain quality and control costs; or

(2) to build or establish health care facilities to meet the requirements of this sub section.

(c) DEFINITIONS.—For purposes of this section:

(1) MEDICALLY UNDERSERVED AREA.—The term medically underserved area means an area that is designated as a health professional shortage area under section 332 of the Public Health Service Act or as a medically underserved area for purposes of section 330 or 1302(7) of such Act.

(2) RURAL AREA.—The term rural area means an area that is not within a Standard Metropolitan Statistical Area or a New England County Metropolitan Area (as defined by the Office of Management and Budget).

(d) IMPLEMENTATION.—The Secretary shall submit to Congress not later than January 1, 2000, a report detailing regulations and a plan for implementation of the details of this section. Such regulations and plan for implementation shall not proceed without the concurrence by joint resolution or Act of the Congress.

SEC. 104. EXCLUSIONS.

Nothing in this subtitle shall be construed—

(1) to require a group health plan, and a health insurance issuer offering health insurance coverage—

(A) to provide particular benefits other than those provided under the terms of such coverage; or

(B) to comply with this subtitle with respect to abortion services or euthanasia services, even if the issuer covers such services;

(2) as forbidding a plan or issuer from offering (or requiring a plan or issuer to offer) abortion or euthanasia services; or

(3) as applying to a fee-for-service plan.

Subtitle B—Promoting Quality Care by Ensuring Access to Health Care Services

SEC. 111. ACCESS TO SPECIALISTS.

(a) IN GENERAL.—A group health plan, and a health insurance issuer that offers health insurance coverage that provides benefits, in whole or in part, through participating health care providers shall demonstrate that participants, beneficiaries, and enrollees have access to a specialist when treatment by such specialist is medically or clinically indicated in the professional judgment of the treating

health professional, in consultation with the participant, beneficiary, or enrollee.

(b) DEFINITION.—For purposes of subsection (a), the term "specialist" means a health professional or provider (including a specialty institution) that, through training or experience, has developed the expertise necessary to treat individuals with special health care needs or a chronic condition or disease.

SEC. 112. CONTINUITY OF CARE.

A group health plan, and a health insurance issuer offer health insurance coverage that provides benefits, in whole or in part, through participating health care professionals shall—

(1) ensure that any process established by the issuer to coordinate care and control costs does not create an undue burden, as defined by the applicable State authority, for participants, beneficiaries, and enrollees with special health care needs or chronic conditions;

(2) ensure direct access to relevant specialists for the continued care of participants, beneficiaries, and enrollees when medically or clinically indicated in the judgment of the treating health professional, in consultation with the participant, beneficiary, or enrollee;

(3) in the case of a participant, beneficiary, or enrollee with special health care needs or a chronic condition, determine whether, based on the judgment of the treating health professional, in consultation with the participant, beneficiary, or enrollee, it is medically or clinically necessary to use a specialist or a care coordinator from an interdisciplinary team to ensure continuity of care; and

(4) in circumstances under which a change of health professional or provider might disrupt the continuity of care for a participant, beneficiary, or enrollee, provide for continued coverage of items and services furnished by the health professional or provider that was treating the participant, beneficiary, or enrollee before such change for a reasonable period of time.

A change of health professional or provider may be due to changes in the membership of an issuer's health professional and provider network, changes in the health coverage made available by an employer, or other similar circumstances.

SEC. 113. ACCESS TO EMERGENCY ROOM CARE.

(a) EMERGENCY CARE.—

(1) IN GENERAL.—If a group health plan, or a health insurance issuer offering health insurance

coverage provides any benefits with respect to emergency services (as defined in subsection (b)(2)), the plan or issuer shall cover emergency services furnished under the plan or coverage—

(A) without the need for any prior authorization determination;

(B) whether or not the health care professional or provider furnishing such services is a participating professional or provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee by a non-participating health care professional or provider, the participant, beneficiary, or enrollee is not liable for an amount that exceeds the amount of financial liability that would be incurred if the services were provided by a participating health care professional or provider; and

(D) without regard to any other term or condition of such plan or coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701 of the Employee Retirement Income

Security Act of 1974, and other than applicable through cost-sharing).

(b) DEFINITIONS.—For purposes of this section:

(1) EMERGENCY MEDICAL CONDITION.—The term "emergency medical condition" means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(2) EMERGENCY SERVICES.—The term "emergency services" means—

(A) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capabilities of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition (as defined in paragraph (1)), and

(B) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as required under section 1867 of such Act to stabilize the patient.

(3) STABILIZE.—The term ''to stabilize'' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

(c) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—In the case of services (other than emergency services) for which benefits are available under a group health plan or health insurance issuer offering health insurance coverage, the plan or issuer shall provide for reimbursement with respect to such services provided to a participant, beneficiary, or enrollee other than through a participating health care professional or provider in a manner consistent with subsection (a)(1)(C) if the services are maintenance care or post-stabilization care covered under the guidelines established under section 1852(d)(2) of the Social Security Act (relating to promoting efficient and timely coordination of

appropriate maintenance and post-stabilization care of an enrollee after an enrollee has been determined to be stable), in accordance with regulations established to carry out such section.

SEC. 114. PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

(a) IN GENERAL.—In any case in which a group health plan or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, and provides benefits under the terms of the plan consisting of—

(1) routine gynecological care (such as preventive women's health examinations), or

(2) routine obstetric care (such as routine pregnancy-related services), provided by a participating professional who specializes in such care (or provides benefits consisting of payment for such care),

if the primary care provider designated by such a participant, beneficiary, or enrollee is not such a professional, then the plan or issuer shall meet the requirements of subsection (b).

(b) REQUIREMENTS.—A group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, meets the requirements of

this paragraph, in connection with benefits described in subsection (a), if the plan or issuer—

(1) does not require authorization or a referral by the primary care provider in order to obtain such benefits, and

(2) treats the ordering of other routine care of the same type, by the participating professional providing the care described in subsection (a) as the authorization of the primary care provider with respect to such care.

(c) CONSTRUCTION.—Nothing in subsection (b) shall waive any exclusions of coverage under the terms of the plan with respect to coverage of gynecological or obstetric care so ordered.

SEC. 115. PATIENT ACCESS TO PEDIATRIC CARE.

(a) IN GENERAL.—In any case in which a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, provides benefits consisting of routine pediatric care provided by a participating physician who specializes in pediatrics (or consisting of payment for such care) and the plan or issuer requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, the plan or issuer shall provide that such a participating physician may be designated, if available, by a par-

ent or guardian of any beneficiary under the plan who is under 18 years of age, as the primary care provider with respect to any such benefits.

(b) CONSTRUCTION.—Nothing in subsection (a) shall waive any exclusions of coverage under the terms of the plan with respect to coverage of pediatric care.

SEC. 116. EXCLUSIONS.

Nothing in this subtitle shall be construed—

(1) to require a group health plan, and a health insurance issuer offering health insurance coverage—

(A) to provide particular benefits other than those provided under the terms of such coverage; or

(B) to comply with this subtitle with respect to abortion services or euthanasia services, even if the issuer covers such services;

(2) as forbidding a plan or issuer from offering (or requiring a plan or issuer to offer) abortion or euthanasia services; or

(3) as applying to a fee-for-service plan.

Subtitle C—Promoting Quality Care by Ensuring Fair Resolution of Grievances

SEC. 121. UTILIZATION REVIEW STANDARDS.

The utilization review program of a group health plan, and a health insurance issuer that provides health insurance coverage, shall—

(1) be developed (including any screening criteria used by such program) with the involvement of participating health professionals and providers;

(2) to the extent consistent with the protection of proprietary business information (as defined for purposes of section 552 of title 5, United States Code) release, upon request, to affected health professionals, providers, and enrollees the screening criteria, weighting elements, and computer algorithms used in reviews and a description of the method by which they were developed;

(3) uniformly apply review criteria;

(4) subject to reasonable safeguards, disclose to health professionals and providers and enrollees, upon request, the names and credentials of individuals conducting utilization review;

(5) not compensate individuals conducting utilization review under a system that provides financial

or other incentives or bonuses for denials of payment or coverage of benefits;

(6) comply with the requirement of section 113 that prior authorization not be required for emergency and related services furnished in a hospital emergency department; and

(7) provide timely access, as defined by the applicable State authority, to utilization review personnel and, if such personnel are not available, waives any prior authorization that would otherwise be required.

SEC. 122. INTERNAL AND EXTERNAL REVIEW PROCEDURES.

(a) COVERAGE DETERMINATIONS.—A group health plan and a health insurance issuer offering health insurance coverage shall—

(1) provide notice in writing in accordance with this section to any participant or beneficiary in a group health plan, or any enrollee in health insurance coverage offered by a health insurance issuer, of any adverse coverage decision with respect to benefits of such participant, beneficiary, or enrollee, setting forth the specific reasons for such coverage decision and any rights of review, written in a manner calculated to be understood by the participant, beneficiary, or enrollee;

(2) provide written notice to any treating health care professional of such participant, beneficiary, or enrollee if such professional has claimed reimbursement for any item or service involved in such coverage decision, or if a claim submitted by the professional initiated the proceedings leading to such decision;

(3) afford an opportunity to any participant, beneficiary, or enrollee who is in receipt of the notice of such adverse coverage decision and who files a written request for review of the initial coverage decision within 180 days after receipt of the notice of the initial decision, for a full and fair de novo review of the decision by a person who did not make the initial decision; and

(4) meet the additional requirements of this section.

(b) TIME LIMITS FOR MAKING INITIAL COVERAGE DECISIONS FOR BENEFITS AND COMPLETING INTERNAL APPEALS.—

(1) TIME LIMITS FOR DECIDING REQUESTS FOR BENEFIT PAYMENTS AND REQUESTS FOR ADVANCE DETERMINATION OF COVERAGE.—Except as provided in paragraph (2)—

(A) INITIAL DECISIONS.—If a request for benefit payments, or a request for advance determination of coverage is submitted to a group health plan or a health insurance issuer offering health insurance coverage in such form as may be required under the plan or coverage, the plan or issuer shall issue in writing an initial coverage decision on the request not later than 7 days (or such longer period as may be prescribed in regulations of the Secretary) after the date as of which the plan or issuer is in receipt of all information required (in writing or in such other form as may be specified under the plan or coverage) to make an initial coverage decision. Failure to issue a coverage decision on such a request by such deadline shall be treated as an adverse coverage decision for purposes of internal review under subparagraph (B).

(B) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant, beneficiary, or enrollee for review of an initial adverse coverage decision under subparagraph (A), a review by an internal appeals entity of the initial coverage decision shall be com-

pleted, including issuance by the plan or issuer of a written decision affirming, reversing, or modifying the initial coverage decision, setting forth the grounds for such decision, not later than 14 days (or such longer period as may be prescribed in regulations of the Secretary) after the date as of which the entity is in receipt of all information required (in writing or in such other form as may be specified under the plan or coverage) to make a decision to affirm, modify, or reverse the coverage decision. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration. Failure to issue by such deadline such a written decision requested under this subparagraph shall be treated as a final decision affirming the initial coverage decision, subject to any applicable reconsideration.

(2) TIME LIMITS FOR MAKING COVERAGE DECISIONS RELATING TO URGENT HEALTH CARE AND FOR COMPLETING INTERNAL APPEALS.—

(A) INITIAL DECISIONS.—A group health plan and a health insurance issuer offering health insurance coverage shall issue in writing an initial coverage decision on any request for

expedited advance determination of coverage, in such form as may be required under the plan or coverage, not later than 2 days (or such longer period as may be prescribed in regulations of the Secretary) after the date as of which the plan or issuer is in receipt of all information required (in writing or in such other form as may be specified under the plan or coverage) to make an initial coverage decision. Such decision shall be treated as the final decision of the plan or issuer, subject to any applicable reconsideration. Failure to issue before the end of the applicable decision period such a written decision requested under this subparagraph shall be treated as a final decision affirming the initial coverage decision, subject to any applicable reconsideration.

(B) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant, beneficiary, or enrollee for review of an initial adverse coverage decision under subparagraph (A), if the case involves urgent health care, a review by an internal review entity of the initial coverage decision shall be completed, including issuance by the plan or issuer of a

written decision affirming, reversing, or modifying the initial coverage decision, setting forth the grounds for the decision, not later than 2 days (or such longer period as may be prescribed in regulations of the Secretary) after the date as of which the entity is in receipt of all information required (in writing or in such other form as may be specified under the plan or coverage) to make a decision to affirm, modify, or reverse the coverage decision. Such decision shall be treated as the final decision of the plan or issuer, subject to any applicable reconsideration. Failure to issue before such deadline such a written decision requested under this subparagraph shall be treated as a final decision affirming the initial coverage decision, subject to any applicable reconsideration.

(c) REQUIREMENT FOR REVIEW OF INITIAL COVERAGE DECISIONS BY A PHYSICIAN.—If an initial coverage decision is based on a determination other than that provision of a particular item or service is excluded from coverage under the terms of the plan or coverage, the review shall be conducted by a physician who is selected to serve as an internal appeals entity under the plan or coverage and who did not make the initial denial.

(d) EXTERNAL REVIEW BY INDEPENDENT MEDICAL EXPERTS AND RECONSIDERATION OF INITIAL REVIEW DECISION.—

(1) IN GENERAL.—The requirements of paragraphs (2), (3), and (4) shall apply—

(A) in the case of any failure to timely issue a coverage decision upon internal review which is deemed to be an adverse coverage decision (thereby failing to constitute a coverage decision for which specific reasons have been set forth as required), and

(B) in the case of any adverse coverage decision not based on a determination that provision of a particular item or service is excluded from coverage under the terms of the plan or coverage because the provision of such item or service is specifically excluded as a benefit of the plan or coverage.

(2) RECONSIDERATION OF INITIAL REVIEW DECISION.—In any case in which a participant, beneficiary, or enrollee who has received an adverse decision of the plan or issuer upon review of the initial coverage decision and who has not commenced review of the initial coverage decision makes a request in writing, within 30 days after the date of such re-

view decision, for reconsideration of such review decision, the terms of the plan or coverage shall provide for a procedure for such reconsideration paid for by the plan or issuer under which—

(A) one or more independent medical experts will be selected to review the coverage decision described;

(B) the record for review (including a specification of the terms of the plan or coverage and other criteria serving as the basis for the initial review decision) shall be presented to such expert or experts and maintained in a manner which shall ensure confidentiality of such record;

(C) such expert or experts will make and report in writing to the plan or issuer a determination as to whether such coverage decision should be affirmed, modified, or reversed, setting forth the grounds (including the clinical basis) for the determination; and

(D) the determination of such expert or experts pursuant to subparagraph (C) shall be considered binding on the plan or issuer.

(3) TIME LIMITS FOR RECONSIDERATION.—Any review under this subsection shall be completed not

later than 14 days (or, in the case of a decision involving urgent health care, 2 days, or such longer period as may be prescribed in regulations of the Secretary) after the date as of which the independent medical expert or experts involved is in receipt of all information required (in writing or in such other form as may be specified under the plan or coverage) to make a decision to affirm, modify, or reverse the coverage decision. Failure to issue a written decision before such deadline in any reconsideration requested under this subsection shall be treated as a final decision affirming the initial review decision of the plan or issuer.

(4) INDEPENDENT MEDICAL EXPERTS.—

(A) IN GENERAL.—For purposes of this section, the term "independent medical expert" means, in connection with any coverage decision by a group health plan or health insurance issuer, a health care professional who—

(i) is a physician or, if appropriate, another health care professional;

(ii) has appropriate credentials and has attained recognized expertise in the applicable health care field;

(iii) was not involved in the initial decision or any earlier review thereof; and

(iv) is selected in accordance with subparagraph (B).

(B) SELECTION OF MEDICAL EXPERTS.—An independent medical expert is selected in accordance with this subparagraph if—

(i) the expert is selected by an intermediary which itself meets the requirements of subparagraph (C), by means of a method which ensures that the identity of the expert is not disclosed to the plan or issuer, any health insurance issuer offering health insurance coverage to the aggrieved participant, beneficiary, or enrollee in connection with the plan, and the aggrieved participant, beneficiary, or enrollee under the plan, and the identities of the plan, the issuer, and the aggrieved participant, beneficiary, or enrollee are not disclosed to the expert;

(ii) the expert is selected, by an appropriately credentialed panel of health care professionals meeting the requirements of subparagraph (C) established by

a fully accredited teaching hospital meeting such requirements;

(iii) the expert is selected by an organization described in section 1152(1)(A) of the Social Security Act which meets the requirements of subparagraph (C);

(iv) the expert is selected by an external review organization which meets the requirements of subparagraph (C) and is accredited by a private standard-setting organization meeting such requirements and recognized as such by the Secretary; or

(v) the expert is selected under regulations issued pursuant to negotiated rulemaking, sufficient to ensure the expert's independence, and the method of selection is devised to reasonably ensure that the expert selected meets the independence requirements of subparagraph (C).

(C) INDEPENDENCE REQUIREMENTS.—An independent medical expert or another entity described in subparagraph (B) meets the independence requirements of this subparagraph if—

(i) the expert or entity is not affiliated with any related party;

(ii) any compensation received by such expert or entity in connection with the external review is reasonable and not contingent on any decision rendered by the expert or entity;

(iii) under the terms of the plan and any health insurance coverage involved, the plan and the issuer (if any) have no recourse against the expert or entity in connection with the external review; and

(iv) the expert or entity does not otherwise have a conflict of interest with a related party as determined under any regulations which the Secretary may prescribe.

(D) RELATED PARTY.—For purposes of this paragraph, the term ''related party'' means—

(i) with respect to—

(I) a group health plan or health insurance coverage offered in connection with such a plan, the plan or the health insurance issuer offering such coverage, or

(II) individual health insurance coverage, the health insurance issuer offering such coverage,

or any officer, director, or management employee of such plan or issuer;

(ii) the health care professional that provided the health care involved in the coverage decision;

(iii) the institution at which the health care involved in the coverage decision is provided;

(iv) the manufacturer of any drug or other item that was included in the health care involved in the coverage decision; or

(v) any other party determined under any regulations which the Secretary may prescribe to have a substantial interest in the coverage decision.

(E) AFFILIATED.—For purposes of this paragraph, the term "affiliated" means, in connection with any entity, having a familial, financial, or professional relationship with, or interest in, such entity.

(F) LIMITATION ON LIABILITY.—An individual serving on as an independent medical ex-

pert or an entity acting as such under this paragraph shall not be held liable for any decision made except in cases of gross negligence, recklessness, or intentional misconduct by such individual or entity.

(5) INAPPLICABILITY WITH RESPECT TO ITEMS AND SERVICES SPECIFICALLY EXCLUDED FROM COVERAGE.—An adverse coverage decision based on a determination that an item or service is excluded from coverage under the terms of a plan or health insurance coverage shall not be subject to review under this section.

(e) PENALTIES AGAINST AUTHORIZED OFFICIALS FOR DENIAL OF EXTERNAL REVIEW.—

(1) MONETARY PENALTIES.—In any case in which review by an independent medical expert or experts of a benefit is denied by a group health plan, or by a health insurance issuer offering health insurance coverage, any person who, acting in the capacity of determining the necessity of such a review, causes such denial may, in the court's discretion, be liable to the aggrieved participant, beneficiary, or enrollee for a civil penalty in an amount of up to $750 a day from the date on which the recommendation was made to the plan or issuer until

the date the failure to provide review is corrected, up to a total amount not to exceed $250,000.

(2) CEASE AND DESIST ORDER AND ORDER OF ATTORNEY'S FEES.—In any action described in paragraph (1) brought by a participant, beneficiary, or enrollee with respect to a group health plan, or a health insurance issuer offering health insurance coverage, in which the plaintiff alleges that a person referred to in such paragraph has taken an action resulting in a denial of review by independent medical expert or experts in violation of such terms of the plan, coverage, or this title, or has failed to take an action for which such person is responsible under the plan, coverage, or this title and which is necessary under the plan or coverage for allowing such review, the court shall cause to be served on the defendant an order requiring the defendant—

(i) to cease and desist from the alleged action or failure to act; and

(ii) to pay to the plaintiff a reasonable attorney's fee and other reasonable costs relating to the prosecution of the action on the charges on which the plaintiff prevails.

(3) ADDITIONAL CIVIL PENALTIES.—

(A) IN GENERAL.—In addition to any penalty imposed under paragraph (1) or (2), the appropriate Secretary may assess a civil penalty against a person acting in the capacity of determining the necessity of external review for one or more group health plans, or health insurance issuers offering health insurance coverage, for—

(i) any pattern or practice of repeated denial of review by independent medical expert or experts in violation of the terms of such a plan, coverage, or this title; or

(ii) any pattern or practice of repeated violations of the requirements of this section with respect to such plan or plans or coverage.

(B) STANDARD OF PROOF AND AMOUNT OF PENALTY.—Such penalty shall be payable only upon proof by clear and convincing evidence of such pattern or practice and shall be in an amount not to exceed the lesser of—

(i) 25 percent of the aggregate value of benefits shown by the appropriate Secretary to have not been provided, or unlaw-

fully delayed, in violation of this section under such pattern or practice, or

(ii) $500,000.

(4) REMOVAL AND DISQUALIFICATION.—Any person acting in the capacity of determining the necessity of external review who has engaged in any such pattern or practice described in paragraph (3)(A) with respect to a plan or coverage, upon the petition of the appropriate Secretary, may be removed by the court from that position, and from any other involvement, with respect to such a plan or coverage, and may be precluded from returning to any such position or involvement for a period determined by the court.

(f) DEFINITIONS.—For purposes of this section:

(1) ADVANCE DETERMINATION OF COVERAGE.—The term "advance determination of coverage" means a determination under a group health plan, and a health insurance issuer offering health insurance coverage that proposed health care meets, under the facts and circumstances at the time of the determination, the plan or issuer's terms and conditions of coverage (which may be subject to exceptions under the plan for fraud or misrepresentation).

(2) ADVERSE COVERAGE DECISION.—The term "adverse coverage decision" means any request for payment of benefits, determination of coverage, advance determination of coverage, or expedited advance determination of coverage made by a group health plan, or a health insurance issuer offering health insurance coverage, that does not affirm the treatment decision of the treating health care professional.

(3) REQUEST FOR ADVANCE DETERMINATION OF COVERAGE.—The term "request for advance determination of coverage" means a request for an advance determination of coverage of health care which is made by or on behalf of a participant, beneficiary, or enrollee before such health care is provided.

(4) REQUEST FOR BENEFIT PAYMENTS.—The term "request for benefit payments" means a request, for payment of benefits by a group health plan, or health insurance issuer offering health insurance coverage for health care, which is made by or on behalf of a participant, beneficiary, or enrollee after such health care has been provided.

(5) REQUEST FOR EXPEDITED ADVANCE DETERMINATION OF COVERAGE.—The term "request for expedited advance determination of coverage"

means a request for advance determination of coverage, in any case in which the proposed health care constitutes urgent health care.

(6) URGENT HEALTH CARE.—The term "urgent health care" means health care in any case in which a physician has certified in writing (or as otherwise provided in regulations of the Secretary) that failure to provide the participant, beneficiary, or enrollee with such health care within 7 days can reasonably be expected to result in either—

(A) the imminent death of the participant, beneficiary, or enrollee; or

(B) the immediate, serious, and irreversible deterioration of the health of the participant or beneficiary which will significantly increase the likelihood of death of, or irreparable harm to, the participant, beneficiary, or enrollee.

(7) WRITTEN OR IN WRITING.—A request or decision shall be deemed to be "written" or "in writing" if such request or decision is presented in a generally recognized printable or electronic format. The appropriate Secretary may by regulation provide for presentation of information otherwise required to

be in written form in such other forms as may be appropriate under the circumstances.

Subtitle D—Promoting Quality Care by Ensuring Fair Plan Administration

SEC. 131. RESTRICTIONS ON INCENTIVE PLANS.

(a) INCENTIVE PLANS.—

(1) IN GENERAL.—In the case of a group health plan, and a health insurance issuer that offers network coverage, any health professional or provider incentive plan operated by the plan or issuer with respect to such coverage shall meet the following requirements:

(A) No specific payment shall be made directly or indirectly under the plan to a professional or provider or group of professionals or providers as an inducement to reduce or limit medically necessary services provided with respect to a specific participant, beneficiary, or enrollee.

(B) If a plan or issuer places such a professional, provider, or group at substantial financial risk (as determined by the Secretary) for services not provided by the professional, provider, or group, the plan issuer shall provide

stop-loss protection for the professional, provider, or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of professionals or providers placed at such substantial financial risk in the group or under the coverage and the number of individuals enrolled with the plan or issuer who receive services from the professional, provider, or group.

(2) NOTIFICATION.—The plan or issuer shall provide the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this section.

(b) HEALTH PROFESSIONAL OR PROVIDER INCENTIVE PLAN DEFINED.—In this subsection, the term health professional or provider incentive plan means any compensation arrangement between a health insurance issuer and a health professional or provider or professional or provider group that has the effect of reducing or limiting services provided with respect to individuals enrolled with the plan or issuer.

(c) CONSTRUCTION.—Nothing in this section shall be construed as prohibiting all capitation and similar arrangements or all provider discount arrangements.

(d) IMPLEMENTATION.—The Secretary shall submit to Congress not later than January 1, 2000 a report detailing regulations and a plan for implementation of the details of this section. Such regulations and plan for implementation shall not proceed without the concurrence by joint resolution or Act of the Congress.

SEC. 132. DEVELOPMENT OF PLAN AND ISSUER POLICIES.

A group health plan, and a health insurance issuer that offers network coverage shall establish mechanisms to consider the recommendations, suggestions, and views of participants, beneficiaries, enrollees and participating health professionals and providers regarding—

(1) the medical policies of the plan or issuer (including policies relating to coverage of new technologies, treatments, and procedures);

(2) the utilization review criteria and procedures of the plan or issuer;

(3) the quality and credentialing criteria of the plan or issuer; and

(4) the medical management procedures of the plan or issuer.

SEC. 133. PATIENT ACCESS TO INFORMATION.

(a) DISCLOSURE REQUIREMENTS.—

(1) IN GENERAL.—A group health plan or health insurance issuer providing health insurance

coverage shall take such actions as necessary to ensure that—

(A) information required under subsections (b) through (k) is provided at the time of enrollment, at least annually thereafter, and upon written request; and

(B) the information described in subsection (l) is provided upon written request,

to plan participants and beneficiaries and to enrollees, respectively.

(2) INCLUSION IN SUMMARY PLAN DESCRIPTION.—In the case of a group health plan, the information described in paragraph (1)(A) shall be made available as part of the summary plan description of the plan.

(3) CHARGING FOR INFORMATION MADE AVAILABLE UPON REQUEST.—In cases in which the information is made available upon written request under paragraph (1), the plan or issuer may impose a reasonable charge to cover the cost of making the information so available. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under this paragraph.

(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

(1) COVERED ITEMS AND SERVICES.—

(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

(i) types of items and services (including any special disease management program); and

(ii) types of health care professionals providing such items and services.

(B) EMERGENCY MEDICAL CARE.—A description of—

(i) the extent to which the plan or health insurance coverage covers emergency medical care;

(ii) the locations of hospital emergency departments, urgent care centers, and other sites or settings in which the plan or health insurance coverage makes available emergency medical care or post-stabilization care; and

(iii) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations, and an explanation of what constitutes an emergency situation.

(C) PREVENTATIVE SERVICES.—A description of the extent to which the plan or health insurance coverage provides benefits for preventative services.

(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

(E) COBRA CONTINUATION COVERAGE.—In the case of a group health plan, a description of the benefits available under the plan pursuant to part 6 of the Employee Retirement Income Security Act.

(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for health care is limited or excluded on the basis of utilization review or preauthorization requirements.

(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used by the plan for custodial care.

(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any health care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided under the plan or coverage for the relevant terminology referring to such limited or excluded care.

(F) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

(G) SPECIALTY CARE.—A description of the circumstances under which, and the extent

to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

(H) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

(I) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the plan or health insurance coverage, in covering emergency medical care furnished to a participant or beneficiary of the plan or enrollee imposes any financial responsibility described in subsection (c) on participants or beneficiaries or enrollees or limits or conditions benefits for such care subject to any other term or condition of such plan or coverage.

(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

(1) a participant's or enrollee's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges; and

(2) the circumstances under which, and the extent to which, the participant's or enrollee's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted by the plan pursuant to section 122, including—

(1) descriptions relating specifically to—

(A) coverage decisions;

(B) internal review of coverage decisions; and

(C) any external review of coverage decisions;

(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1); and

(3) the number of external review cases conducted annually and, of such number, the number of such cases where the decision of the plan or issuer

is upheld and the number of such cases where the decision of the plan or issuer is modified or overturned.

(e) NETWORK CHARACTERISTICS.—If the plan or health insurance issuer utilizes a defined set of providers under contract with the plan or issuer, the information required under subsection (a) includes a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

(f) CARE MANAGEMENT INFORMATION.—The information required under subsection (a) includes a description of the circumstances under which, and the extent to which, the plan or health insurance issuer has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

(g) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—The information required under subsection (a) includes a statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan or health insurance coverage and a description of the procedures for considering requests for any patient-specific waivers.

(h) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—The information required under subsection (a) includes, upon receipt by the participant or beneficiary or enrollee of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

(i) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—The information required under subsection (a) includes a description of the accreditation and licensing status (if any) of each health insurance issuer (or each such issuer offering health insurance coverage in connection with the plan) and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licensing authority.

(j) MEASURES OF ENROLLEE SATISFACTION.—The information required under subsection (a) includes the latest information (if any) maintained by the plan (or by any health insurance issuer offering health insurance coverage in connection with the plan) or by the health insurance issuer relating to enrollee satisfaction.

(k) QUALITY PERFORMANCE MEASURES.—The information required under subsection (a) includes the latest information (if any) maintained by the plan (or by any

health insurance issuer offering health insurance coverage in connection with the plan) or by the health insurance issuer, relating to quality of performance of the delivery of health care with respect to coverage options offered under the plan or health insurance coverage and of health care professionals and facilities providing health care under the plan or coverage.

(l) INFORMATION AVAILABLE ON REQUEST.—Pursuant to written request under subsection (a)(1)(B)—

(1) INFORMATION REQUIRED FROM INDIVIDUAL HEALTH CARE PROFESSIONALS ON REQUEST.— Any health care professional treating a participant or beneficiary under a group health plan or an enrollee under health insurance coverage shall provide to the participant or beneficiary or enrollee, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such health care under the plan or coverage.

(2) INFORMATION REQUIRED FROM INDIVIDUAL HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant, beneficiary, or enrollee has sought treatment under a group health plan or health insurance coverage shall provide to the participant, beneficiary, or enrollee, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

(m) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective date of any exclusion of a specific drug or biological from any drug formulary under the group health plan or health insurance coverage that is used in the treatment of a chronic illness or disease, the plan or issuer shall take such actions as are necessary to reasonably ensure that plan participants or enrollees are informed of such exclusion. The requirements of this subsection may be satisfied—

(1) in the case of a group health plan, by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations;

(2) by timely informing participants or enrollees who, under an ongoing program maintained under the plan or health insurance issuer, have submitted their names for such notification; or

(3) by any other reasonable means of timely informing participants or enrollees.

SEC. 134. PROTECTION OF CONFIDENTIALITY.

(a) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall establish mechanisms and procedures to ensure compliance with applicable Federal and State laws to protect the confidentiality of individually identifiable information held by the plan issuer with respect to a participant, beneficiary, enrollee, health professional, or provider.

(b) INDIVIDUALLY IDENTIFIABLE INFORMATION DEFINED.—For purposes of subsection (a), the term "individually identifiable information" means, with respect to a participant, beneficiary, enrollee, a health professional, or a provider, any information, whether oral or recorded in any medium or form, that identifies or can readily be associated with the identity of the participant, beneficiary, enrollee, the health professional, or the provider.

SEC. 135. DUE PROCESS FOR HEALTH PROFESSIONALS AND PROVIDERS.

(a) IN GENERAL.—A group health plan, and a health insurance issuer, with respect to its offering of network coverage shall—

(1) allow all health professionals and providers in its service area who are licensed, accredited, or certified to perform specific health services consistent with State law and those services covered under the network coverage to apply to become a participating health professional or provider as openings in a network become available during at least one period in each calendar year;

(2) provide reasonable notice to such health professionals and providers of the opportunity to apply and of the period during which applications are accepted;

(3) provide for review of each application by a credentialing committee with representation of the category or type of health professional or provider being credentialed;

(4) select participating health professionals and providers using objective standards of quality developed with the suggestions and advice of professional associations, health professionals, and providers;

(5) make such selection standards available to—

(A) those applying to become a participating provider or health professional;

(B) purchasers of health insurance coverage; and

(C) participants, beneficiaries, or enrollees;

(6) when economic considerations are taken into account in selecting participating health professionals and providers, use objective criteria that are available to those applying to become a participating provider or health professional and participants, beneficiaries, or enrollees;

(7) adjust any economic profiling to take into account patient characteristics (such as severity of illness) that may result in atypical utilization of services;

(8) make the results of such profiling available to insurance purchasers, enrollees, and the health professional or provider involved;

(9) notify any health professional or provider being reviewed under the process referred to in paragraph (3) of any information indicating that the health professional or provider fails to meet the standards of the issuer;

(10) offer a health professional or provider receiving notice pursuant to the requirement of paragraph (9) with an opportunity to—

(A) review the information referred to in such paragraph; and

(B) submit supplemental or corrected information;

(11) not include in its contracts with participating health professionals and providers a provision permitting the issuer to terminate the contract without cause;

(12) provide a due process appeal that conforms to the process specified in section 412 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11112) for all determinations that are adverse to a health professional or provider; and

(13) unless a health professional or provider poses an imminent harm to enrollees or an adverse action by a governmental agency effectively impairs the ability to provide health care items and services, provide—

(A) reasonable notice of any decision to terminate a health professional or provider for cause (including an explanation of the reasons for the determination);

(B) an opportunity to review and discuss all of the information on which the determination is based; and

(C) an opportunity to enter into a corrective action plan, before the determination be comes subject to appeal under the process referred to in paragraph (12).

(b) RULES OF CONSTRUCTION.—The requirements of subsection (a) shall not be construed as preempting or superseding any other reviews and appeals a group health plan, or a health insurance issuer are required by law to make available. Nothing in subsection (a) shall be construed to require a group health plan or a health insurance issuer to renew a contract with a participating provider.

SEC. 136. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) IN GENERAL.—Subject to subsections (b) and (c), a group health plan, and a health insurance issuer (in relation to an individual enrolled under health insurance coverage offered by the issuer) shall not prohibit or otherwise restrict a covered health care professional (as defined in subsection (d)) from advising such an individual who is a patient of the professional about the health status of the individual or health care or treatment for the individuals condition or disease, regardless of whether benefits

for such care or treatment are provided under the coverage, if the professional is acting within the lawful scope of practice.

(b) CONSCIENCE PROTECTION.—Subsection (a) shall not be construed as requiring a group health plan or a health insurance issuer to provide, reimburse for, or provide coverage of a counseling or referral service if the issuer—

(1) objects to the provision of such service on moral or religious grounds; and

(2) in the manner and through the written instrumentalities such issuer deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the issuer adopts a change in policy regarding such a counseling or referral service.

(c) CONSTRUCTION.—Nothing in subsection (b) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

SEC. 137. PLAN SOLVENCY.

A group health plan and a health insurance issuer offering health insurance coverage shall—

(1) meet such financial reserve or other solvency-related requirements as the applicable State authority may establish to assure the continued availability of (and appropriate payment for) covered items and services for enrollees; and

(2) establish mechanisms specified by the applicable State authority to protect enrollees, health professionals, and providers in the event of failure of the issuer.

Such requirements shall not unduly impede the establishment of health insurance issuers owned and operated by health care professionals or providers or by nonprofit community-based organizations.

SEC. 138. QUALITY ASSESSMENT PROGRAM.

(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage shall establish a quality assessment program (consistent with subsection (b)) that systematically and continuously assesses—

(1) participant, beneficiary, or enrollee health status, patient outcomes, processes of care, and participant, beneficiary, or enrollee satisfaction associated with health care provided by the plan or issuer; and

(2) the administrative and funding capacity of the issuer to support and emphasize preventive care, utilization, access and availability, cost effectiveness, acceptable treatment modalities, specialists referrals, the peer review process, and the efficiency of the administrative process.

(b) FUNCTIONS.—A quality assessment program established pursuant to subsection (a) shall—

(1) assess the performance of the plan or issuer and its participating health professionals and providers and report the results of such assessment to purchasers, participating health professionals and providers, and administrative personnel; and

(2) analyze quality assessment data to determine specific interactions in the delivery system (both the design and funding of the health insurance coverage and the clinical provision of care) that have an adverse impact on the quality of care.

Subtitle E—Definitions

SEC. 151. DEFINITIONS.

(a) INCORPORATION OF GENERAL DEFINITIONS.—Except as otherwise provided, the provisions of section 2971 of the Public Health Service Act shall apply for purposes of this title in the same manner as they apply for purposes of title XXVII of such Act.

(b) SECRETARY.—Except as otherwise provided, the term "Secretary" means the Secretary of Health and Human Services, in consultation with the Secretary of Labor and the Secretary of the Treasury and the term "appropriate Secretary" means the Secretary of Health and Human Services in relation to carrying out this title under sections 2706 and 2751 of the Public Health Service Act and the Secretary of Labor in relation to carrying out this title under section 713 of the Employee Retirement Income Security Act of 1974.

(c) ADDITIONAL DEFINITIONS.—For purposes of this title:

(1) APPLICABLE AUTHORITY.—The term "applicable authority" means—

(A) in the case of a group health plan, the Secretary of Health and Human Services and the Secretary of Labor; and

(B) in the case of a health insurance issuer with respect to a specific provision of this title, the applicable State authority (as defined in section 2791(d) of the Public Health Service Act), or the Secretary of Health and Human Services, if such Secretary is enforcing such provision under section 2722(a)(2) or 2761(a)(2) of the Public Health Service Act.

(2) ENROLLEE.—The term "enrollee" means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

(3) FEE-FOR-SERVICE COVERAGE.—The term "fee-for-service coverage" means coverage that—

(A) reimburses hospitals, health professionals, or other providers, directly or by payment to enrollees who are required to pay such parties, on the basis of a rate determined by the issuer on a fee-for-service basis without placing the provider at financial risk;

(B) does not vary reimbursement for the coverage period for such a provider based on an agreement to contract terms and conditions or the utilization of health care items or services relating to such provider or enrollees; and

(C) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established by the issuer; and

(D) for which the issuer does not utilize prospective or concurrent review.

(4) GROUP HEALTH PLAN.—The term "group health plan" has the meaning given such term in section 733(a) of the Employee Retirement Income Security Act of 1974.

(5) HEALTH PROFESSIONAL.—The term "health professional" means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

(6) NETWORK.—The term "network" means, with respect to a group health plan or health insurance issuer offering health insurance coverage, the participating health professionals and providers through whom the plan or issuer provides health care items and services to participants, beneficiaries, or enrollees.

(7) NETWORK COVERAGE.—The term "network coverage" means, with respect to a group health plan or health insurance coverage offered by a health insurance issuer, health benefits coverage that provides or arranges for the provision of health care items and services to participants, beneficiaries, or enrollees through participating health professionals and providers.

(8) NONPARTICIPATING.—The term "non-participating" means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

(9) PARTICIPATING.—The term "participating" means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage offered by a health insurance issuer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

(10) PRIOR AUTHORIZATION.—The term "prior authorization" means the process of obtaining prior approval from a health insurance issuer for the treatment of a medical or clinical condition.

(11) PROVIDER.—The term "provider" means a health organization, health facility, or health agency that is licensed, accredited, or certified to provide health care items and services under applicable State law.

(12) SERVICE AREA.—The term "service area" means, with respect to a health insurance issuer with respect to health insurance coverage, the geographic area served by the issuer with respect to the coverage.

(13) UTILIZATION REVIEW.—The term "utilization review" means prospective, concurrent, or retrospective review of health care items and services, and includes prior authorization requirements for coverage of such items and services.

(d) ABORTION AND EUTHANASIA SERVICES DEFINED.—For purposes of this sections 104 and 116:

(1) ABORTION SERVICES.—The term "abortion services" means the performance of an abortion, the providing of drugs to induce an abortion, and services related directly to the performance of an abortion (such as the performance of ultrasound and similar preparatory procedures and preparation of post-abortion pathology reports), but does not include the treatment of injuries or illnesses caused by an abortion.

(2) EUTHANASIA SERVICES.—The term "euthanasia services" means anything for which the use of funds appropriated by the Congress is prohibited under the Assisted Suicide Funding Restriction Act

of 1997 (Public Law 105–12; 42 U.S.C. 14401 et seq.), subject to sections 3(b) of such Act (42 U.S.C. 14402(b)).

(e) APPLICATION TO PARTNERSHIPS.—The provisions of paragraphs (1), (2), and (3) of section 732(d) of the Employee Retirement Income Security Act of 1974 shall apply with respect to partnerships.

SEC. 152. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

(1) IN GENERAL.—Subject to paragraph (2), this title shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers (in connection with group health insurance coverage or otherwise) except to the extent that such standard or requirement prevents the application of a requirement of this title.

(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this title shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income

Security Act of 1974 with respect to group health plans.

(b) RULES OF CONSTRUCTION.—Nothing in this title shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

(c) DEFINITIONS.—For purposes of this section:

(1) STATE LAW.—The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) STATE.—The term "State" includes a State, the Northern Mariana Islands, any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

SEC. 153. REGULATIONS.

The Secretaries of Health and Human Services, Labor, and the Treasury shall issue such regulations as may be necessary or appropriate to carry out this title. Such regulations shall be issued consistent with section 104 of Health Insurance Portability and Accountability Act of 1996. Such Secretaries may promulgate any in-

terim final rules as the Secretaries determine are appropriate to carry out this title.

TITLE II—APPLICATION OF QUALITY CARE STANDARDS TO GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE UNDER PUBLIC HEALTH SERVICE ACT

SEC. 201. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

"SEC. 2706. PATIENT PROTECTION STANDARDS.

"(a) IN GENERAL.—Each group health plan shall comply with patient protection requirements under title I of the Access to Quality Care Act of 1999, and each health insurance issuer shall comply with patient protection requirements under such title with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

"(b) NOTICE.—A group health plan shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) and

a health insurance issuer shall comply with such notice requirement as if such section applied to such issuer and such issuer were a group health plan.".

(b) CONFORMING AMENDMENT.—Section 2721(b)(1)(A) of such Act (42 U.S.C. 300gg–21(b)(1)(A)) is amended by inserting "(other than section 2706)" after "requirements of such subparts".

SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2751 the following new section:

"SEC. 2752. PATIENT PROTECTION STANDARDS.

"(a) IN GENERAL.—Each health insurance issuer shall comply with patient protection requirements under title I of the Access to Quality Care Act of 1999 with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

"(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of such title as if such section applied to such issuer and such issuer were a group health plan.".

TITLE III—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SEC. 301. APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

"SEC. 713. PATIENT PROTECTION STANDARDS.

"A group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of title I of the Access to Quality Care Act of 1999 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this section.".

SEC. 302. ERISA PREEMPTION NOT TO APPLY TO CERTAIN ACTIONS INVOLVING HEALTH INSURANCE POLICYHOLDERS.

(a) IN GENERAL.—Section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended by adding at the end the following subsection:

"(e) PREEMPTION NOT TO APPLY TO CERTAIN ACTIONS ARISING OUT OF PROVISION OF HEALTH BENEFITS.—

"(1) IN GENERAL.—Except as provided in this subsection, nothing in this title shall be construed to invalidate, impair, or supersede any cause of action under State law to recover damages resulting from personal injury or for wrongful death against any person—

"(A) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan (as defined in section 733), or

"(B) that arises out of the arrangement by such person for the provision of such insurance, administrative services, or medical services by other persons.

"(2) EXCEPTION FOR EMPLOYERS AND OTHER PLAN SPONSORS.—

"(A) IN GENERAL.—Subject to subparagraph (B), paragraph (1) does not authorize—

"(i) any cause of action against an employer or other plan sponsor maintaining the group health plan, or

"(ii) a right of recovery or indemnity by a person against an employer or other plan sponsor for damages assessed against the person pursuant to a cause of action under paragraph (1).

"(B) SPECIAL RULE.—Subparagraph (A) shall not preclude any cause of action described in paragraph (1) against an employer or other plan sponsor if—

"(i) such action is based on the employer's or other plan sponsor's exercise of discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and

"(ii) the exercise by such employer or other plan sponsor of such authority resulted in personal injury or wrongful death.

"(C) EXCEPTION.—The exercise of discretionary authority described in subparagraph (B)(i) shall not be construed to include—

"(i) the decision to include or exclude from the plan any specific benefit;

"(ii) any decision affirming the decision of a treating health care professional; or

"(iii) any decision to provide benefits beyond those specified in the plan at the request of a treating health care professional.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to acts and omissions occurring on or after the date of the enactment of this Act from which a cause of action arises.

SEC. 303. DIRECT ACCESS TO COURTS.

Section 502 of the Employee Retirement Income Security Act is amended—

(1) in subsection (a)(8) by striking "or" at the end;

(2) in subsection (a)(9) by striking the period at the end and inserting "; or";

(3) by adding at the end of subsection (a) the following new paragraph:

"(10) by a participant or beneficiary for appropriate relief under subsection (b)(4)."; and

(4) by adding at the end of subsection (b) the following new paragraph:

"(4) In any case in which exhaustion of administrative remedies otherwise necessary for an action for relief has not been obtained and it is demonstrated to the court by means of certification by an appropriate physician that such exhaustion is not reasonably attainable under the facts and circumstances without undue risk of irreparable harm to the health of the participant or beneficiary, a civil action may be brought by a participant or beneficiary to obtain appropriate equitable relief. Any determinations made while an action under this paragraph is pending shall be given due consideration by the court in any such action.".

TITLE IV—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

SEC. 401. EFFECTIVE DATES.

(a) GROUP HEALTH COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by sections 201(a) and 301 (and title I insofar as it relates to such sections)

shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after January 1, 2000 (in this section referred to as the "general effective date") and also shall apply to portions of plan years occurring on and after such date.

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by sections 201(a) and 301 (and title I insofar as it relates to such sections) shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(B) the general effective date.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the

plan solely to conform to any requirement added by this Act shall not be treated as a termination of such collective bargaining agreement.

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The amendments made by section 202 shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

SEC. 402. COORDINATION IN IMPLEMENTATION.

Section 104(1) of Health Insurance Portability and Accountability Act of 1996 is amended by striking "this subtitle (and the amendments made by this subtitle and section 401)" and inserting "the provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of parts A and C of title XXVII of the Public Health Service Act, chapter 100 of the Internal Revenue Code of 1986, and title I of the Access to Quality Care Act of 1999".

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